



DPH Lab ID

Medical Director:
Daniel Terreros M.D., Ph.D.

SECTION 1. PATIENT INFORMATION (REQUIRED)**

| | | | | | |
|--|-----|--|--------|---|------------|
| Patient name-Last** | | First** | M.I. | Phone () | |
| Address-Number, street, apt #** | | | City** | State** | ZIP Code** |
| Date of birth** / / | Age | Sex** <input type="checkbox"/> Male <input type="checkbox"/> Female | | If female, is the patient pregnant? <input type="checkbox"/> Yes (weeks pregnant) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| Hospital: <input type="checkbox"/> Outpatient <input type="checkbox"/> ER <input type="checkbox"/> Inpatient | | Location if admitted _____ | | | |
| Institution: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) _____ | | | | | |
| Symptoms that occurred during illness (check all that apply): | | | | | |
| <input type="checkbox"/> Rash | | <input type="checkbox"/> Conjunctivitis | | <input type="checkbox"/> Nausea/vomiting | |
| <input type="checkbox"/> Joint Pain | | <input type="checkbox"/> Headache | | <input type="checkbox"/> Guillain-Barré Syndrome | |
| <input type="checkbox"/> Fever _____ °F | | <input type="checkbox"/> Muscle pain | | <input type="checkbox"/> Other _____ | |
| Date of symptom onset / / | | Date of admission / / | | Medical Record# | |
| Travel history in last 12 weeks (list cities, counties, states, or countries visited and dates of travel) | | | | | |

SECTION 2. SUBMITTER INFORMATION (REQUIRED)**

| | | | | | |
|---|--|----------------|-----------------------------|---|----------|
| Hospital/Facility name** | | | Ordering physician's name** | | |
| Address-Number, street, apt # | | City | County | State | ZIP Code |
| Contact (Results will be faxed to this contact)** | | Phone** () | | Fax (Results will be faxed to this number)** () | |

SECTION 3. SPECIMEN INFORMATION

| | |
|--|---|
| Date of collection** / / | Time of collection** : <input type="checkbox"/> AM <input type="checkbox"/> PM |
| Test Requested <input checked="" type="checkbox"/> RT-PCR Zika, Chikungunya, and Dengue | |
| Specimen source or type** Urine, CSF, and amniotic fluid samples must be accompanied with a serum sample | |
| <input type="checkbox"/> Serum <input type="checkbox"/> Urine <input type="checkbox"/> CSF <input type="checkbox"/> Amniotic Fluid | |
| Serum must be removed from the clot and transferred to a separate leak-proof container | |
| Minimum volume for serum and CSF is 1 mL | |
| Minimum volume for urine and amniotic fluid is 0.5 mL | |
| Urine and amniotic fluid will be tested for Zika only | |
| All other sample types will be tested for Zika, Chikungunya, and Dengue | |
| Samples that will arrive at the lab within the same day of collection can be stored at 2-8°C and shipped with cold packs. | |
| Samples that will arrive at the lab more than 24hrs after collection should be stored at ≤-20°C and shipped on dry ice. | |

LABORATORY USE ONLY

SECTION 4. SPECIMEN CONDITION

Specimen condition: Refrigerated (cold packs) Frozen Unacceptable _____

SECTION 5. RT-PCR RESULTS

| | |
|--|---|
| <input type="checkbox"/> No Zika, dengue, or chikungunya RNA detected by rRT-PCR <input type="checkbox"/> Dengue RNA detected by rRT-PCR. No Zika or chikungunya RNA detected. <input type="checkbox"/> Chikungunya RNA detected by rRT-PCR. No dengue or Zika RNA detected. <input type="checkbox"/> Dengue and chikungunya RNA detected by rRT-PCR. No Zika RNA detected. <input type="checkbox"/> Zika and dengue RNA detected by rRT-PCR. No chikungunya RNA detected <input type="checkbox"/> Zika and chikungunya RNA detected by rRT-PCR. No dengue RNA detected <input type="checkbox"/> Zika, dengue, and chikungunya RNA detected by rRT-PCR <input type="checkbox"/> Specimen inconclusive for the presence of Zika RNA by rRT-PCR. An inconclusive result result may occur in the case of an inadequate specimen. <input type="checkbox"/> Zika RNA detected by rRT-PCR <p>Negative results do not rule out dengue, chikungunya and/or Zika virus infections and should not be used as the sole basis for patient management decisions. Negative results must be combined with clinical observations, patient history, and epidemiological information. Samples may be forwarded to the Texas Department of State Health Services or CDC laboratory for antibody (IgM) or PRNT testing based on clinical symptoms, PCR results and epidemiological criteria.</p> | Reference Range: No Zika, dengue, or chikungunya RNA detected |
|--|---|

Report Date: _____ Report Time: _____ AM PM Analyst: _____